From ‘holding pen’ to ‘a space to breathe’

From 'holding pen' to 'a space to breathe': affective landscapes in a newly-integrated sexual health clinic

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ABSTRACT

This paper examines the role of affective landscapes in the formation of attendees' experiences at a re-provisioned, integrated sexual and reproductive healthcare facility. The 'One-Stop Shop' (OSS) is an example of the organisational shift towards integrated services occurring across the UK, bringing together in one clinic the historically discreet services of genitourinary medicine, HIV medicine and Family Planning. An ethnographically-informed study of new spaces of care and changed organisation, this paper focuses on the experiences of 29 attendees as they made their way along the clinic's care pathways. Drawing on concepts of affect and atmosphere to augment the analytic lens of 'therapeutic landscapes', this paper demonstrates how various spaces of the clinic influenced attendees' experiences. A cramped, featureless 'holding pen', the foyer served to exacerbate pre-existing anxieties while creating new fears. The main waiting room, an organisational sorting space, both soothed and aggravated attendees' concerns. Serving as an architectural feature to connect the old Victorian hospital with the new clinical extension, the atrium was experienced as a space to breathe, with an affective atmosphere that challenged the assumed unpleasantness of sexual health clinics. This paper demonstrates how affective landscapes of the clinic shape attendee experiences in a novel setting.

Keywords: Integrated sexual health; 'Therapeutic landscapes'; place and affect; major service change

INTRODUCTION

In the UK, the provision of sexual and reproductive healthcare has historically been made available through the specialties of genitourinary medicine (GUM), HIV medicine, family planning (FP), and primary care (GP) (French et al 2006). While GUM and HIV medicine practitioners historically focused on the acute needs of their patients in hospital settings, FP emphasised prevention, providing attendees with contraceptive strategies delivered by women, for women, within the community (Gillespie 2002). From these divergent roots sprung two very different professional and care cultures, characterised by differing pay grades, professional status and approaches to patient care (Kane and Wellings 1999). Since the early 1990s, however, calls for the integration of GUM, HIV medicine and FP have gained traction (Department of Health 2001). It has been argued that the distinction between attendees of FP services on the one hand, and GUM

and HIV medicine attendees on the other, is no longer best suited to address the converging sexual and reproductive healthcare needs of the population (French et al 2006). Integration of services, it is argued, encourages comprehensive, horizontal sexual and reproductive healthcare provision by acknowledging the closely related needs of attendees while improving cost-efficiency of care (French et al 2006). These rationales have driven policies promoting strategic healthcare change, including the UK's first ever national sexual health strategy, Better prevention, Better services, Better Sexual Health (DoH 2001), calling for the development of broad partnerships and collaboration in the provision of sexual and reproductive healthcare.

Despite these changes, there exists only a handful of published evaluations of attendee views and experiences of integration. Existing studies focus overwhelmingly on the 'One-Stop Shop' (hereafter OSS) – a model of service provision wherein a full range of services are brought together 'under one roof' and care is provided by comprehensively trained practitioners (Gray et al 2009). Studies have discussed a number of concerns that influence attendees' preferences for, or rejection of, integrated services over 'stand-alone' options, including the location and accessibility of the clinic (French et al 2006), staff attitudes (Griffiths et al 2008), interpersonal relationships and the presence of other attendees (Griffiths et al 2008), competency of delivery and confidentiality (Griffiths et al 2008) and stigma (Gray et al 2009; Sauer et al 2013). Summarising key concerns, it is clear that stakeholders are worried about possible changes in the clinic environment, staff attitudes and expertise, and the presence of 'others' in these new facilities. Yet, given that integration of services involves consolidating all services within one facility, it is surprising that none of the existing studies have placed a spatial lens on the question of the experience of such facilities. This study addresses this gap, by focusing on the link between organisational change, clinic design and attendee experiences. The following section introduces the spatial concepts used to explore and understand the experiences of attendees as they encountered, and made their way through, the clinic.

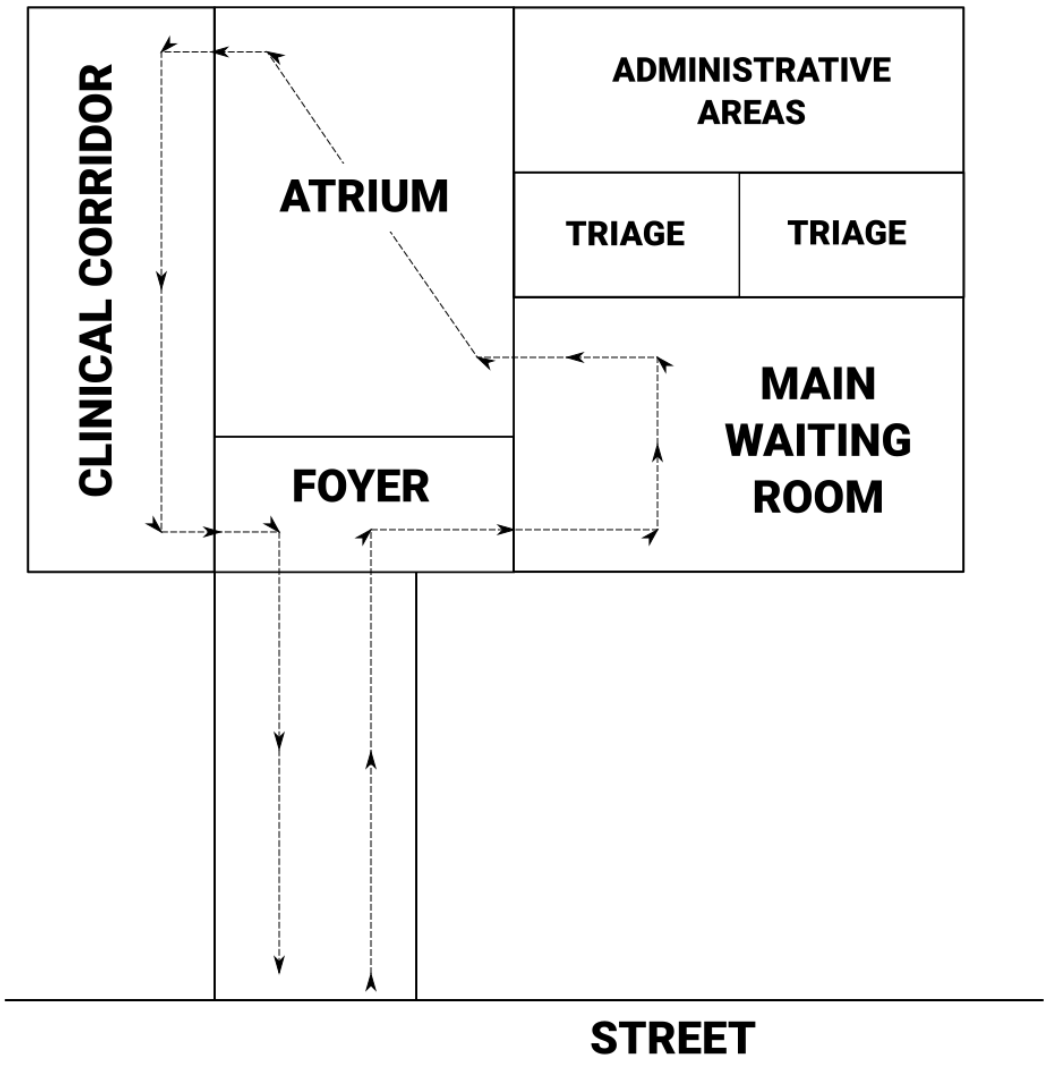
From 'Therapeutic landscapes' to 'affective landscapes'

'Therapeutic landscapes' emerged as a concept to examine the way in which naturally occurring landscapes and spiritual retreats were linked to healing (Gesler 1992). Comprised of composite affective elements - the physical (material), social (power dynamics and interactions) and symbolic (artefacts, objects and language) - 'therapeutic landscapes' calls for consideration of the affect created by these interconnected environments (Gesler 1992). From its origins as a concept applied to the natural world and spiritual spaces of healing, 'therapeutic landscapes' has been adopted as a means through which to examine experiences of psychiatric facilities (Curtis et al 2007; Wood et al 2015); hospital design (Gesler et al 2004); complementary therapy and imagined spaces (Andrews 2004); paediatric hospitals (Kearns and Barnett 1999); the family planning clinic (Gillespie 2002); and dementia care homes (McClean 2007) among others. Thus, 'therapeutic landscapes' has been used as a conceptual tool for examining experiences of a range of healthcare facilities. In addition, however, the concept has also been influential for research into other spaces and settings as diverse as prisons (Moran and Turner 2018), 'care farming' and non-human engagements with therapeutic place (Gorman 2017), and entire cities (Wakefield and McMullan 2005). What is evident in the literature is that landscapes have an affect on those experiencing them and that attending to these experiences through a spatial lens provides a unique understanding of the social world. Yet, while 'therapeutic landscapes' has proved a popular heuristic device to be applied to examinations of place experience, the concept nevertheless veils somewhat the intangibility of affect, and how we might approach understandings thereof. This is where considerations of both affect and

atmosphere in relation to place experience come in useful, as a way of enhancing our understanding of peoples' encounters with 'therapeutic landscapes'.

Affect might be understood as 'a pre-personal field of intensity' and is positioned as the pure, essential force which is then filtered through embodied, social registers in order to be sensed and expressed (McCormack 2008: 414). Affect is at times conflated with 'atmosphere', as Anderson notes, 'in everyday speech and aesthetic discourse, the word atmosphere is used interchangeably with mood, feeling, ambience, tone and other ways of naming collective affects' (2009: 78). What 'atmosphere' and 'affect' share in common is a certain inaccessibility, as existing outside of, or beyond language (Bohme 1993). Yet, somewhat paradoxically, the word is used to relate to specific situations in common parlance, for example, 'applied to persons, spaces and to nature' (Bohme 1993:113). We can recognise that 'on entering a room one can feel oneself enveloped by a friendly atmosphere or caught up in a tense atmosphere. We can say of a person that s/he radiates an atmosphere' (Bohme 1993: 113). So, what is the difference between 'affect' and 'atmosphere'? Bissell (2010) suggests that the latter is the spatialisation of the former. Indeed, atmosphere has a 'propensity: a pull or a charge that might emerge in a particular space which might (or might not) generate particular events and actions, feelings and emotions' (Bissell 2010: 273). Bringing affect and atmosphere together, Bille, Bjerregaard and Sorensen (2015) suggest the concept of 'affective atmospheres' as a way of understanding the 'staging' of design, through the use of objects, light and symbols. Yet, the staging of affective atmospheres is subject to perception and experience and, as such, spaces are occupied and acted upon. Rather, atmospheres are 'perpetually forming and deforming, appearing and disappearing, as bodies enter into relation with one another. They are never finished, static or at rest' (Anderson 2009: 79).

This paper make a number of contributions. First, it contributes to 'therapeutic landscapes' by applying this theoretical lens to a new type of setting – an integrated sexual and reproductive healthcare OSS, and in doing so addresses the enduring lack of attention awarded to spaces of sexual and reproductive healthcare provision in sociological literature. Second, the inclusion of 'affect', 'atmosphere' and 'affective atmospheres' to the theoretical approach offer a way of thinking about 'therapeutic landscapes' that allows for consideration of the limitations of language in communicating experience of place (see Methods). Finally, this paper demonstrates the contributions that can be made by applying ethnographic research findings to debates around policy change and integrated service delivery in sexual and reproductive health.



(Figure 1) Map of the clinic layout and directional flow of pathways

(Figure 2) Top left: Entryway; Top-right: Foyer; Bottom-right: Main waiting room; Bottom-left: atrium

The 'walk-in' access route offers the opportunity to arrive at the facility unscheduled, without an appointment. The 'walk-in' runs from 8.30am - 10am, Monday to Friday, although access into a peripheral foyer waiting area is available from 7am, providing a discrete waiting area, as well as shelter from the inclement weather. Each attendee to the 'walk-in' must pick up a numbered triage card, on display in the foyer, in order to be assessed by the triage nurse. The cards specify the rules of access to the 'walk-in', which include noting that 'if an urgent walk-in slot is not required the nurse will explain how best to get an appointment with a GP'.

Once inside the main waiting room, those who have attended the 'walk-in' are called up, one by one, for triage ('number 1 please', 'number 2 please' and so on), their numbered card serving as a queuing system while also preserving anonymity in the public space of the waiting room. Once inside triage, the healthcare practitioner (HCP) asks each attendee to outline their reason for attending. Based upon what the attendee says the HCP will make one of three decisions. Providing that they can say 'no' to a list of questions outlined on the reverse side of the triage card, asymptomatic attendees will be placed on the 'No-Talk testing' (hereafter NTT) care pathway, to be screened for four of the most common STIs – gonorrhoea (GC), chlamydia (CT), HIV and Syphilis - without having to undergo a consultation. Symptomatic attendees assessed as appropriate for an 'urgent walk-in slot' are placed onto the general clinic care pathway. Once triaged, the attendee returns to the main waiting room in order to register with a member of the reception team, located at one of three desks running up the right-hand side of the space. If the individual is allocated a place on the NTT pathway, however, they will be directed downstairs to a smaller waiting room, without having to register. Those who are not provided with a space at the clinic on either care pathway are sent away.

Unlike 'walk-in' attendees, booked appointment holders phone a dedicated phone line, at which point the operator will offer possible appointment dates. It is not uncommon for there to be a wait of at least a month for the intrauterine contraception clinic (hereafter IUC), where women are fitted with long-acting reversible contraception including the intrauterine device (Cu-IUD) or

the LNG-IUS intrauterine system (Mirena®), which releases Levonorgestrel into the uterus. Booked appointment holders are required to present to a member of the reception team when they arrive, before being directed straight into the clinical wing of the facility for their appointment.

METHODS

This paper draws upon ethnographically-informed research designed to understand attendees' experience of the clinic. These methods, described below, were chosen to encourage active engagement in the real time practices and rhythms of the clinic, and to equally prioritise the verbal communication between myself and the participants (interviews, informal chats) and the expression of affective response to the spaces of the clinic. Indeed, the strength of combining interviews and observations is that there is the possibility of going beyond what is said by social actors, allowing for both the subjective articulation of experience, and observation of the otherwise 'unreported', routine and subconscious human behaviours within their context, in real time (Guest et al 2013; Thrift 2004).

Recruitment commenced at the 'walk-in' in January 2014 and finished when I sent out my last wave of postal invites for booked appointment holders in mid-November, with fieldwork ending in December of the same year. While the clinic offers a large number of services to a population with diverse needs, the study in question focused on booked appointment holders to the IUC and those attending the 'walk-in' service. This selection was informed by the principles of 'time, people and context', set out by Hammersley and Atkinsons (1983: 46), with 'walk-in' and booked appointment holders presenting the opportunity to be at the facility at different times of day ('time'), accompanying attendees with various needs ('people') and attending the facility for different reasons ('contexts'). Furthermore, unscheduled 'walk-ins' were included because the walk-in is a popular access route into the facility, but one from which a high number of complaints are generated. Women attending the IUC were chosen for their comparative potential, not only when considering their means of accessing the facility, but also in terms of their arrival time to the clinic, which could range from first thing in the morning through to late afternoon and early evening.

Over the course of the year of fieldwork, I accompanied 16 'walk-in' attendees and 13 booked appointment holders on their journey through the clinic, sitting with them as they waited in various waiting spaces of the facility, observing their consultations, and then leaving the facility together to conduct the interview (see Table 1). Depending on the needs of the attendee, the pathway that they were placed on, these journeys lasted between 20 minutes and almost 4 hours. Taken together, and when including time spent at the clinic waiting for participants, significant time was spent conducting observations at the facility over the year of fieldwork. In addition, most of the interviews lasted an hour or more.

Table 1 Participant details	'Walk-in'	Booked appointments
Decade of birth		
1960s	-	1
1970s	3	8
1980s	9	4
1990s	4	-
Self-identified nationality		
Scottish	4	6
Scottish/Norwegian	1	-
British	8	5
Polish	1	-
Indian	1	-
Welsh	1	-
Irish	-	1
Australian	-	1
Employment status		
Employed	15	11
Unemployed	1	2
Presenting issue		
Symptomatic	8	-
Asymptomatic	5	-
Post-Exposure Prophylaxis	1	-
Contraception	2	-
LNG-IUS fitting	-	6
LNG-IUS replacement	-	2
Cu-IUD replacement	-	4
Implant fitting	-	1
Assigned pathway		
'NTT'	3	-
General clinic	13	-
Booked appointment	-	13

A note on engaging with 'walk-in' attendees

While recruitment of the booked appointment holders used a familiar approach – postal invitation packs - recruiting from the 'walk-in' involved more creative thinking, due to the unpredictability of the pathway and the practical obstacles this presented. I designed an A4 information poster introducing myself and the study, and attached this to the back of the laminate cards required for access to the 'walk-in'. Triage nurses acted as gatekeepers in the recruitment of 'walk-in' participants, asking individuals if they wished to take part in the research. Despite fears that recruitment from the 'walk-in' would be ineffectual in such a transient and potentially sensitive setting, this was not the case. Indeed, on several occasions individuals waiting in the main waiting room approached me, as I sat behind the reception desk, to ask if they could take part, this without having been asked by the triage nurse. This receptiveness to the study was entirely unexpected, and challenges assumptions about stigma, shame and preferences for privacy that were anticipated by all involved in the project, including the ethics panel, clinicians, front-line staff and myself.

During my time at the clinic, I relied upon 'head notes' (Emerson et al, 1995) to collect data, this instead of visibly writing notes down. I made this decision for two key reasons. First, I did not wish to make others around me – who were not the focus of my study – feel monitored. Second, I wished to dedicate my time to the individual with whom I was with, rather than compromising this by writing notes. Participants were generally talkative and, when they were not, we just waited along with everyone else around us, preoccupied by our phones, reading magazines or watching the silent television screens. If my presence created some behavioural change among those with whom we were waiting, it was not obvious to me. Of course, the situation for the participating attendees was different, as we were engaged in an ongoing interaction and, as such, their awareness of their role in the research would almost certainly have influenced their behaviour. This said, on the occasion that participants did speak of the impact of my presence on their experience, it was positive – linked to the idea of not being alone, as indicated by a number of participants, including Danny, who said, 'Well, today, because I was sitting with you I felt really comfortable. It felt ok. Other times, you feel a little bit tense because you are aware that other people are looking at you'. Finally, as a person who has used sexual health clinics and views these sites – and the people who use them – positively, I never felt uncomfortable spending time at the clinic.

'Head-notes' were developed into full field-notes at the end of each day, which, along with transcriptions, helped shape my thinking while fieldwork was ongoing. Once I entered a period of intentioned analysis, I familiarised myself with the textual materials I had generated. I then began coding, inductively and deductively, using highlighter pens, scissors, glue and cards, based on a priori interests of the research as well as new insights (Maxwell 2012). Codes included: 'anxiety', 'knowledge of facility', 'risk', 'preconceptions', 'social landscape', 'stigma', and 'responsibility'. This process gave me a clear, visual representation of my findings. However, findings, described below, are limited and situated. They re-present the experiences that were shared with me by participants at a particular moment in their lives. As Bloch notes, reflecting on ethnographic research, 'the long conversation which the anthropologist observes has begun long before he came' and continues on after they leave (1977: 278). In this way, the findings in this paper will only ever be 'snapshots' of a much more complicated reality that remains beyond what is captured and re-told herein. Finally, the study received ethical approval from the university's Research Ethics Committee.

FINDINGS

In this section, I discuss the ways in which the component 'sorting spaces' of the facility, that is, the foyer, the main waiting room and the atrium, worked to, reinforce, through the convergence of its affective landscapes, the sense that sexual health services are different and deservedly lesser than other healthcare facilities, or alleviate these fears through their affective impact.

Arrival: Waiting in the 'holding pen'

The 'frontier' (Mattingly 2010) spaces of the facility are comprised of the outer boarded walkway and adjacent entry sign, the boundary wall, the raised walkway, the double set of heavy automatic glass doors and, finally, the foyer. The foyer itself has few features other than a leaflet stand, a wall mounted dispenser for laminated triage numbers, and objects to encourage appropriate self-governance, namely, a large CCTV wall-mounted monitor, and a notice stating the institution's 'zero tolerance' approach to rude and inappropriate behaviour. Most notably, not only is the foyer unfurnished, without seating, it has three sets of doors (the aforementioned glass doors to the outside, plus two sets of inner doors: a sliding wooden door into the main reception, and a door for egress back into the foyer once an attendee has completed their clinic journey). As a consequence of the featureless landscape, the presence of doors, and the lack of seating, the foyer's

architectural design symbolises its purpose as a space for movement and temporality - a space for those who are 'not yet arrived' (Mattingly 2010: 8).

Attendees commonly had to wait in the foyer – an experience that was difficult for many. Accounts often conveyed feelings of discomfort, social anxiety and uncertainty. The foyer was referred to in a number of ways by participants, including 'the holding pen', 'the non-waiting, waiting room', and 'that wee place'. The lack of seating was experienced as symbolically loaded. Penny, a young medic who had visited the facility once before in order to get her IUC fitted, was returning because she believed she had contracted genital herpes. In Penny's opinion, while the foyer gave people an alternative to standing in the street looking like 'tramps', it was nevertheless strange that there were no seats. Penny's reaction to the lack of chairs points to her sense that the foyer is a different kind of space and one that would not be acceptable in any other type of clinic. Penny's negative view of the foyer was not unique. In fact, all of the participants found it an unpleasant waiting area, for reasons linked to the combined affect of its small size, lack of seating and the forced social intimacy that resulted. Libby, who was attending the clinic after living with painful symptoms of infection for several months, explained:

> 'It was kin…probably like intimidating, like everyone was just, it was just silent… no-one was really speaking. No-one made eye contact or anything'.

Libby continued, saying:

> 'I just like walked in and there was like ten people just like all up against the wall sitting on the floor (uh-huh). And I walked in behind a guy and he got a ticket so I was like 'ok, I take it I have to have one of these' so I got a ticket (uh-huh) and then took a seat on the floor with everyone else [laughing]'.

In Libby's account, she speaks of what Hirscheuer, in an ethnographic study of elevator rides, calls the 'social constitution of an asocial space' (2005: 52). Goffman describes what he calls "civil inattention", whereby "one gives to another enough visual notice to demonstrate that one appreciates that the other is present (and that one admits openly to having seen him) while at the next moment withdrawing one's attention from him so as to express that he does not constitute a target of special curiosity or design' (1963: 84). Hirscheuer applies this concept to the ethnographic study of an elevator ride, to characterise how people act in tune with one another to create a space that is devoid of interaction. It is this 'civil inattention' that resulted in Libby experiencing the foyer as 'intimidating' and 'awkward'. With no-one talking, and people avoiding eye contact, Libby simply sat down, using her phone as a 'prop' until the main reception became accessible. Libby's response to the social space of the foyer is something that others spoke of – a type of practicing of, or way of being in, the space, this linking to Bissell's notion of the propensity of atmosphere already mentioned above. In other words, there is an affect that governs action among those within the place, and generates emotions or feeling - a disciplinary capacity of the atmosphere within the frontier (Bissell 2007).

Stuart, a middle-aged gay man who feared he was going through seroconversion[1] at the time that I met him, said he still found the atmosphere in the foyer uneasy, despite being familiar with the social landscape of the facility from previous visits:

> 'Aye, in that wee place [gesticulating towards the foyer] thinking oh these people can, you know, they can see you and they're like, 'oh, I know why you're here, I know why you're here', umm, and that's a wee bit embarrassing'.

For Stuart, the source of his embarrassment is that he feels everyone knows why he is there, and that there is nowhere to hide, so to speak, a concern which echoes some of the gay men included in the study of the acceptability of integrated service provision by Griffiths et al (2008).

More often than not, attendees to the clinic spoke of the foyer in negative terms. It was experienced as a space of forced social intimacy, an intimidating space, an embarrassing space, and a space that served to compound their sense of uncertainty and anxiety. It signalled to them that this was a different type of healthcare facility. This experience of social confinement among others exacerbated the anxieties attendees to the 'walk-in' often felt due to preconceptions of stigma attached to the service and the acute personal health concerns they were facing.

Admission: The main waiting room

Crossing the interior threshold from the foyer, one enters the main waiting room. This 'sorting space' is painted in a light, bright tone, incorporating moments of colour in cool, calm green and blue. It is spacious compared to the foyer, and the two triage rooms sit at the far end of the room. The main waiting room acts as the threshold between the public and private spaces of the facility. Triage nurses and reception staff categorise individuals under organisational labels (NTT, general clinic or booked appointment), determining the care pathway each attendee will follow.

Attendees appeared pleasantly surprised by the appearance of the space, describing it with complimentary adjectives such as 'bright', 'light', and 'open'. Roisin, who had spent time in the foyer, said:

> 'I really liked the green décor of the nurses' things, um, rooms. You know, it's a nice, big space, there's a nice atmosphere to it'.

For Roisin, the main waiting room was contrary to what she had expected. Having never been to a sexual health clinic before her only experience of such a facility was what she had seen on 'a reality TV show' about a sexual health clinic in England, in which the facility 'came across a bit grim'. The fact that she had also spent some 45 minutes sitting on the floor in the foyer had done little to change her expectation:

> 'I don't know, I guess you know it's a grotty test – you get to sit in a grotty place'. But it wasn't, you know, it was spacious and, you know, plenty of chairs, so yeah, it's nice'.

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[1] Defined as the period of time – generally a few weeks after initial infection – when an individual's HIV antibodies develop and rise to detectable levels. Seroconversion can cause flu-like symptoms to occur, including muscle aches, fever, rash and swelling of lymph nodes (Aidsmap.com, 2018).

It was not only those who spent time in the foyer who found the aesthetic of the main waiting room unexpectedly pleasing. Pippa, who was attending the facility via the booked appointment pathway, also used the adjective 'grotty' when talking about her expectations of the facility. Unlike Roisin, Pippa had been to many different sexual and reproductive health care facilities in her lifetime, including the now closed 'stand-alone' FP service, where she had attended for some fifteen years. In fact, it was Pippa's memory of the waiting room at the FP clinic that caused her to expect the new facility to be 'grotty' as well:

> 'It's a lot more… clean and clinical in its appearance but that's not a bad thing. You know, [there] you'd be sitting in the waiting room. The waiting rooms were grotty whereas in there it's clean, it's fresh, it looks bright'.

For Roisin and Pippa, the appearance of the main waiting room at the facility –its proportions, use of colour, cleanliness and fresh paint – made a positive first impression of the facility that was unexpected. Thinking more specifically about the potential for the affective landscape to be therapeutic, rather than simply aesthetically pleasing, Jules' account of how the main waiting room's aesthetic helped to calm her nerves is insightful. Recounting how she had arrived at the facility 'in quite a state', due to her anxious anticipation around the pain involved in the process of getting her LNG-IUS fitted, Jules noted explicitly that she liked the colours in the main waiting room, as well as the light, for it 'helped me keep my mind off what was about to happen'. The case of Jules demonstrates how the affective landscape of a space can have an effect on mood and emotion – both negatively, as was her response to the exterior of the facility ('corporate, cold') and more positively in the waiting room.

For many, their first impressions were positive, a relief from the cramped conditions of the foyer or their preconceptions of a sexual health facility. Like the foyer before it, however, the main waiting room is socially heterogeneous, the result of the social function of the space to differentiate, categorise and spatially arrange attendees through interaction with gatekeepers. How individual attendees interpreted and perceived those around them influenced their experiences waiting in this communal space.

Harriet, who attended the 'walk-in' because she did not wish to wait for a booked appointment, found the integrated population of the main waiting room difficult, for reasons that appear to be hinged upon concerns over being misclassified:

> 'I don't want to be with the people for drop-in. I don't know why it matters, but I want that sense of community'.

Harriet, who also had found the heterogeneity of the foyer difficult, spoke of a sense of community that was lacking as she waited in the main waiting room. The 'community' Harriet felt she was missing was linked to her previous experiences of attending the 'stand-alone' family planning service – a place where she felt she belonged alongside other attendees whom she perceived as being the same as her. At the 'walk-in', Harriet found herself having to share the space with those that she constructed as 'other' – 'people for drop-in'. Of course, those attending the 'drop-in', as Harriet referred to them, might well have been attending for reasons similar to herself, but her perception was that there was a clear distinction between her and 'them'. Perhaps her most explicit statement was that she worried about touching anything in the main waiting room – a space she regarded as contaminated by the 'grubby fingers' of others attending. In this way, Harriet regarded

the objects in the space, such as the magazines and chairs, as what Douglas calls 'conductors of impurity' (1984: 34).

While some attendees did not appear to feel themselves to be the recipients of other people's judgement within the space, Danny felt that he was on the receiving end of scrutiny. Despite having attended on numerous occasions as part of his routine of self-care as a young gay man, Danny still felt that it was a space wherein he might be stigmatised by others around him:

> D: 'You do look around and wonder, oh they're probably thinking what have I got or, look - what's he in for?
>
> X: 'So you feel a little bit like you might be..'
>
> D: 'Might be judged (*uh-huh*). Like, uh, stereotyped like 'there's another gay man who is constantly getting infections', you know I've already got that stigmatism from being gay, like (*uh-huh*) so I get stigmatised like every single day, and so to come here, I'm expecting the same. Like even sitting in the waiting room everyone's just looking at each other and it's just kind of... just *awkward*'.

For Danny, the main waiting room was a space wherein he was self-conscious of the judgement of those around him. Danny's comment points to what Griffiths et al (2008) found in their study of the acceptability of OSS facilities among potential attendees, including gay men, whereby they note that fear of potential homophobia was raised as a reason for OSSs being viewed as undesirable.

These accounts of the social landscape of the waiting room make reference to the affective quality of the space which is 'never only something personal...[instead] a product of a complex mix between...light, sound, bodies, gestures' (McCormack 2008: 1827-28). Thus, the main waiting room had both therapeutic and un-therapeutic affective qualities.

Crossing the threshold: 'A space to breathe'

The atrium is quieter, much larger, and calmer than both the foyer and main waiting room. Located in the heart of the facility, sounds from outside are more muffled. The atrium has an aesthetic that belies its location within a specialist medical facility. The exterior walls of the old Victorian hospital remain exposed and are juxtaposed against the white, modern architecture of the extension. Park style benches are placed in the grand hallway at the foot of the stairway (although I rarely observed anyone sitting on them). Here, artwork, often commissioned from the local art college, are exhibited on the walls at the foot of the stairway. The flyer racks that hold information on a number of issues, such as HIV testing, infections, and safe relationships are the only reminder within this space of its location within a sexual and reproductive healthcare facility. Crucially, and unlike the other 'sorting spaces' on the journey, the atrium is a space of movement, rather than institutionally mediated stasis. Where the foyer missed an opportunity to address and assuage people's anxieties about attending the clinic, the atrium succeeded, lifting attendees out of their preconceptions of a "grotty" sexual health centre, distracting them from the practical function of population control and thus obscuring some of the anxieties around attending.

Attendees found the atrium to be a welcome reprieve from the waiting spaces of the foyer and main waiting room. Rosa noticed the serenity of the space:

> 'Walking through that door and there's that very open space (uh-huh) I mean it was just like 'oh, wow' kind of thing and it was all, it was kind of more serene than I would've expected…um, I suppose when I know this part of [city name] I know the old hospital when it was here, you know, how it was very much dark corridors and tunnels so I suppose I had that in my head, so it was lovely'.

Harish, attending because he had a rash all over his body and was concerned about it, having had unprotected sex, also made this point, stating:

> 'The whole building itself when you enter the entrance er, looks like it's a very small sort of like clinic, but's actually not – it's quite a huge space 'cause most of it is all underground erm…and I really like the modern bit which is a newly built area on the ground'.

Over the course of my time conducting fieldwork I heard the atrium described to me in a number of ways. Maddie said it reminded her of a museum. Antonia said that she felt it looked like an 'art gallery or library', while Libby felt it was 'just like a uni building, not a doctor's'. As Kraftl and Adey note, 'although each person's first affective relationship with the [place] will be different…there are similarities in the affects and affordances produced by such design elements' (2008: 219).

In the case of the atrium, we can see that, while the places of comparison were different, they were also all the same in that none of them regarded the architectural feature as expected for a health facility. The atrium had a profound symbolic effect on participants as an unanticipated place of calm which was, as Penny put it, 'complementary to the open approach to sexual health they have here'.

From the atrium, participants went on to their consultation and passed through the foyer again on their way out, crossing through an open-air corridor which brings more of the public street into view gradually, until finally they are back on the pavement.

DISCUSSION AND CONCLUSION

This research started with the question of how attendees experienced their visit to a fully integrated sexual and reproductive health care OSS, a question informed by concerns about patient experiences of a facility reshaped by major service change. What I found over the course of fieldwork was that participants' experiences of the facility were strongly shaped in advance by their preconceptions of the facility, personal biography, prior experiences of the care pathways, and social narratives of stigma attached to sexual health. I found that concerns about integration, largely borne of policy debates and professional opinions, had little relevance to participants' actual experience, which appeared to be shaped more by their own needs - 'worrying about some aspect of their body or mind' - than with the practice of integrated services (Stewart 2016). Once at the facility, these preconceptions were then challenged, confirmed and reshaped by the affective propensity of the clinic's affective landscapes. Existing evidence has highlighted little consensus as to the impact of integration on stakeholder experiences and preferences. Yet, in many of these studies, participants were made aware of and asked to focus on the integrated nature of the facility, an approach which my research suggests may not capture the actual experience of many attendees. My findings show the differences between measuring attitudes towards policy, which often necessitates narrowing participants' focus on a single issue, and exploring attendee experiences of place ethnographically. Widening the lens of enquiry beyond the narrow scope of integration, and seeking to explore participants' experience of the facility in their own terms, this study found participants' accounts replete with complex and multiple understandings of the clinic, making it hard to pin down exactly how someone does or does not "experience" integration. Thus, in an era

where the patient 'opinion' is neatly parcelled as a sought after commodity (Lupton 2014), richly-observed qualitative studies which foreground patient's own descriptions of their experiences can provide invaluable depth to inform plans for strategic healthcare change.

Exploring the affective landscapes of the clinic, my findings show how the physical landscape can reinforce or counteract expectations and anxieties of a sexual and reproductive health care facility. The cramped, crowded foyer reinforced the personal anxieties of attendees worried about the stigma of the 'walk-in' service. In contrast, the atrium served to disassociate the clinic from negative perceptions of sexual health care, including ideas of the clinic as 'grotty' and a place to treat deviant behaviour. Thus, my findings demonstrate the power of physical landscapes to ameliorate or exacerbate the anxieties of attending a sexual and reproductive health care facility. There is research to suggest that, in 'therapeutic landscapes', the physical landscape matters far less than the creation of a therapeutic social landscape. For example, in her ethnographic study of the dissident, anti-psychiatric spaces that survivors of mental health institutions appropriate for their grassroots self-help meetings, Laws (2009) points out that spaces do not need to be aesthetically pleasing to be experienced as therapeutic. While I am sympathetic to Laws' summary, I argue that a highly transient outpatient space such as my field site, which is characterised by social stigma and associated felt stigma of attending, where attendance is often experienced self-consciously, coupled with highly transient and rare attendance, there is perhaps a greater need to create a therapeutic aesthetic. In such a therapeutic landscape, where people will not get to know one another, the aesthetic can ameliorate anxieties present in the more transient social landscape.

When considering the implications of my findings for policy and practice, I suggest that the most significant issue is that of the reputation of the integrated facility in terms of how it is viewed by the general public and those attending. Despite the hope that integration will bring with it a diminishing of the stigma associated with GUM and HIV medicine, integration itself, as a policy shift and organisational change, does not appear to be sufficient to diminish social stigma. In a climate where sexual health remains a 'Cinderella service' within the NHS, that is, neglected and under-resourced, the question of how to challenge such influences is a pressing one, not least because stigma serves as a strong deterrent to attending. While it might be difficult for a clinic to challenge the stereotypes that result in making sexual health facilities stigmatized and potentially stigmatising places, it is possible to change the *impression* of the facility among those who do attend. In this regard, and in relation to my findings, I suggest an area for improvement, and action. Gesler (2003) notes that 'therapeutic landscapes' can be improved through design features that can be evaluated in terms of their effectiveness. This study in the context of sexual and reproductive healthcare delivery supports these findings. Investments made to the aesthetics of the spaces that comprise the clinic, such as the inclusion of artwork, natural light and plants, might serve to challenge the status of such services as places for the treatment of social deviance. Yet, while there has been much interest in 'staging' atmospheres of healthcare facilities such as palliative care units, children's hospitals, and hospices, sexual and reproductive healthcare facilities continue to be overlooked.

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